

Chapter Three

Provider Participation Information

Overview

Introduction This chapter reviews the qualifications and requirements for providers, how providers enroll in the Medicaid program, and how to report changes in provider information.

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Qualifications for Enrollment

Assignment of Provider Numbers A prospective provider must apply for and be enrolled in the Medicaid program, be assigned a provider number, and agree to certain conditions of participation before payment can be made for services furnished to Medicaid recipients.

The Medicaid program contracts with Blue Cross and Blue Shield of North Carolina (BCBS) to credential in-state and border-area optometrists who apply for enrollment in the Medicaid program.

The enrollment process for all other in-state optical providers and all out-of-state optical providers begins with DMA. (Refer to Appendix B for telephone numbers.)

Licensure and Certification The provider must be licensed by the appropriate state or federal authority and be certified for participation in Medicare and Medicaid.

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Qualifications for Enrollment, Continued

In-State and Border-area Application Process for Optometrists and Ophthalmologists

The application process for optometrists in-state and in border areas is as follows:

1. An optometrist requests enrollment.
 - ?? In-state optometrists contact their regional BCBS representative. (Refer to Appendix B for telephone numbers.)
 - ?? Providers within 40 miles of the North Carolina border contact the BCBS representative in Durham.
2. BCBS sends an application to the optometrist.
3. The optometrist returns the application to BCBS.
4. BCBS assigns a five-digit number to the optometrist.
5. BCBS sends the optometrist information to DMA.
6. DMA adds a two-digit prefix to BCBS's five-digit number resulting in a seven-digit Medicaid provider number.
7. DMA forwards the information to EDS.
8. EDS enters the optometrist's information into the provider database.
9. EDS sends written notification of approval and billing information to the optometrist.

Out-of-State Application Process for All Optical Service Providers

The application process for out-of-state optical providers, including optometrists, is as follows:

1. A provider delivers Medicaid-covered service (emergency or prior approved) to a Medicaid recipient.
2. The provider requests an enrollment application for DMA's Provider Services unit. (Refer to Appendix B for telephone numbers.)
3. The provider sends the completed application, supporting documentation and the HCFA-1500 claim form for the services that have been rendered to DMA's Provider Services unit. (Refer to Appendix B for addresses.)
4. DMA verifies the recipient's Medicaid eligibility.
5. DMA assigns a seven-digit Medicaid provider number to the provider.
6. DMA enters the provider's information into the provider database.
7. DMA sends written notification of approval to the provider and forwards the claim to EDS for payment.

Conditions of Participation

Conditions of Participation

A provider must comply with the following conditions to participate in the N.C. Medicaid program.

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Conditions of Participation, Continued

Provider Agreements

Physicians signify their compliance with the conditions of participation when they submit a claim for payment. Each claim constitutes an agreement for services provided under the claim.

Records

The provider must agree to keep any records necessary to disclose the extent of Medicaid services the provider furnishes to recipients and any information regarding claim payments for a period of not less than five years from the date of services rendered, unless a longer retention period is required by applicable federal or state law, regulations, or agreements. On request, the provider must furnish the N.C. Medicaid program or its agents, the Secretary of the Department of Health and Human Services or his agents, or the N.C. Medicaid Fraud Control unit any information maintained under the requirements referred to in the preceding sentence, and any information regarding payments claimed by the provider for furnishing services under the N.C. Medicaid program.

Facsimiles and Electronic Signatures

Facsimiles (FAXes) and electronic signatures that meet the Division of Medical Assistance's requirements as listed below are acceptable for supporting Medicaid claims. This policy does not exempt a provider from meeting licensure, certification, enrollment, and accreditation requirements, or other legal and regulatory requirements.

Providers may furnish FAX copies of physicians' orders and certification for Medicaid services provided that prior arrangements for sending FAX information have been made. Although providers are not required to have the original physician signatures on file, it is the provider's responsibility to produce the document with the original signature in the event that additional information is needed during a review of documentation related to the Medicaid claim.

Providers that maintain patient records by computer rather than hard copy may use electronic signatures on valid supporting documentation for Medicaid claims if such entries are appropriately authenticated and dated. The following requirements apply:

- ?? Electronic entries must be dated and accompanied by the unique identifier of a primary author who has reviewed and approved the entry.
 - ?? Computer or other code signatures must be maintained under adequate safeguards.
 - ?? Entry of electronic signatures and codes must be made in a secure environment which prevents unauthorized access to records and which protects the security of patient information being electronically transmitted.
 - ?? Sanctions must be in place and imposed for improper or unauthorized use of stamp, computer key, or other code signatures.
 - ?? The provider agency must have a process for reconstruction of electronic records in the event of a system breakdown.
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Conditions of Participation, Continued

Disclosure Information

The provider must comply with the requirements of the Social Security Act and federal regulations concerning:

1. Disclosure by providers (other than an individual provider or group of providers) of ownership and control information, and
 2. Disclosure of information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid or Title XX services program.
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Payment in Full

Providers must agree to accept as payment in full the amounts paid by the North Carolina Medicaid program for those claims submitted for payment under the program. (See Recipient Billing under Provider Responsibilities.)

Third Party Liability

The provider must agree to take all reasonable measures to ascertain the legal liabilities of third parties, including Medicare and private health insurance to pay for Medicaid-covered services, and if third party liability is established, to bill the third party before filing a Medicaid claim. For the purpose of this provision, the term "third party" includes an individual, institution, corporation, public or private agency who is or may be liable to pay all or part of the medical cost of injury, disease or disability of a Medicaid recipient and to report any such payments as third parties on claims filed for Medicaid payment.

Civil Rights Act

Providers must comply with Title VI of the Civil Rights Act of 1964 that states, "No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation under any program or activity receiving Federal financial assistance."

Rehabilitation and Disabilities

Physicians must comply with the following requirements in addition to the laws specifically pertaining to Medicaid:

- ?? **Section 504 of the Rehabilitation Act of 1973**, as amended, which states, "No otherwise qualified handicapped individual in the United States shall solely by reason of his handicap, be excluded from the participation in, be denied the benefit of, or be subject to discrimination under any program or activity receiving Federal financial assistance."
 - ?? **The Age Discrimination Act of 1975**, as amended, which states, "No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance."
 - ?? **The Americans with Disabilities Act of 1990**, which prohibits exclusion from participation in or denial of services because the agency's facilities are not accessible to individuals with a disability.
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Provider Responsibilities

Verifying Eligibility

Providers are responsible for verifying Medicaid eligibility when a recipient presents for services. (See *Medicaid Eligibility, Overview of the North Carolina Medicaid Program*.)

Noncovered Services

When a noncovered service is requested by a recipient, the provider must inform the recipient either orally or in writing that the requested service is not covered under the Medicaid program and will, therefore, be the financial responsibility of the recipient. This must be done prior to performing the service.

Billing a Medicaid Recipient

Providers may only bill recipients for the following:

- ?? a noncovered service, when the recipient was informed prior to the service that Medicaid would not pay for the service
 - ?? a provider may refuse to accept a Medicaid recipient and bill the recipient as private pay only if the provider informs the recipient that Medicaid will not be billed by the provider for any services but will charge the recipient for all services provided
 - ?? services for which either commercial insurance or Medicare reimbursed the recipient and not the provider
 - ?? services for a Medicare Qualified Beneficiary (MQB) recipient that are not covered by Medicare
 - ?? Medicaid-covered services for a recipient who is Medicare-eligible because of age (65 or older) but who has failed to apply for Medicare
 - ?? prescriptions in excess of the six-per-month limit
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Medicaid Overpayments

The Program Integrity (PI) section of the Division of Medical Assistance (DMA) conducts regular postpayment reviews in an ongoing effort to assure that:

1. Medicaid payments are made only for services that are covered under Medicaid policy.
2. Coding on Medicaid claims correctly reflects services provided.
3. Third party carriers are billed before Medicaid was billed and that providers report any such payments from third parties on claims filed for Medicaid payment.
4. Recipient deductible balance and patient liability have been properly applied to charges.

When overpayments are identified, providers are given written information about the errors and are required to refund the overpayment amount.

Program Integrity Reviews

Program Integrity

PI operates under federal and state laws and regulations that are both stringent and comprehensive. The state rules are found in the North Carolina Administrative Code Title 10, Section 26G, and the federal rules are found in 42 CFR 455.

Information regarding requirements resulting from these laws and rules are provided through provider manuals and monthly Medicaid bulletins.

PI Mission

It is PI's mission to ensure that:

- ?? Medicaid dollars are paid correctly by identifying overpayments to providers and recipients occurring due to error, abuse, or fraud
 - ?? overpayments are recovered and the proper agencies are informed of any potentially fraudulent actions
 - ?? recipients' rights are protected and recipients receive quality care
 - ?? problems found are communicated to appropriate staff, providers or recipients and corrected through education or changes to the policy, procedure, or process, and monitored for corrective action
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Mission Achievement

PI achieves their mission by:

- ?? conducting post payment reviews of:
 - ?? provider billing practices and cost reports
 - ?? payment of claims by the fiscal agent
 - ?? recipient eligibility determinations
 - ?? identifying overpayments for recoupment
 - ?? identifying medical, administrative, and reimbursement policies or procedures that need to be changed
 - ?? educating providers on errors made
 - ?? assessing the quality of care for Medicaid recipients
 - ?? assuring that Medicaid pays for only medically necessary services
 - ?? identifying and referring suspected Medicaid fraud cases to the Attorney General's Office Medicaid Investigations Unit (AGO MIU), other state agencies, professional boards (e.g., boards of pharmacy, dentistry, etc.), or to federal agencies for investigations (e.g., DEA)
 - ?? overseeing recipient fraud and abuse activities by the county departments of social services to assure that recipient overpayments are recouped
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Program Integrity Review, Continued

Determining Areas For Review

PI reviews are initiated for a variety of reasons. The following are some common examples (list not all-inclusive):

- ?? PI investigates specific complaints and referrals. These may come from recipients, family members, providers, state or county agencies, or other DMA sections.
- ?? PI uses a sophisticated Fraud and Abuse Detection System (FADS) which consists of two software products called SPOTLIGHT™ and OmniAlert™.
 1. SPOTLIGHT™ uses fraud and abuse pattern recognition software, algorithms, statistical analysis, fraud filters, queries, and neural net technology to identify fraud and abuse claims.
 2. OmniAlert™ is PI's new client server Surveillance and Utilization Review System (SURS). OmniAlert™ is an on-demand, real-time product that makes comparisons of provider billings to determine aberrant billing patterns among peer groups.
 3. Additional features such as claims imaging, the claims date warehouse, and ad hoc query tools along with SPOTLIGHT™ and OmniAlert™ also make detection and investigation faster.
- ?? Special ad-hoc computer reports are run that target specific issues, procedure codes, or duplications of services, etc.
- ?? Identified billing errors and problems can be linked among similar provider groups and may generate additional investigations to determine their prevalence.
- ?? Random sampling of all claim types are reviewed for possible fraud and abuse.
- ?? EDS refers questionable services identified during claims processing to PI.

Provider Responsibilities With a PI Review

If notified that PI has initiated a review, a provider can ensure the review will be both positive and educational by adhering to the following:

- ?? PI will request medical or financial records either by mail or in person. EDS, as the fiscal agent for DMA, may also request records. The records must substantiate all services and billings to Medicaid. Failure to submit the requested records will result in recoupment of all payments for the services. You must maintain records for five years in accordance with the recordkeeping provisions of your provider participation agreement.
- ?? If you receive a recoupment letter from PI, review the information and details in the letter and chart. You have two (2) options:
 1. If you agree that an overpayment has occurred, use the form sent with the letter to indicate your preferred method for reimbursing DMA. The options include sending a check or having the repayment withheld from future Medicaid payments. (Send the check to DMA Accounts Receivable at the address on the letter. **Do not** send the check to EDS as this could result in duplication of your recoupment.)
 2. If you disagree with the overpayment decision by PI and want a reconsideration review, then return the enclosed hearing request form to the DMA Hearing Unit (at the address on the letter) and indicate whether you request a personal hearing or a paper review. **Please pay close attention to the time frames and procedures for requesting a reconsideration review.**

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Program Integrity Review, Continued

Provider Responsibilities With a PI Review (continued)

Personal hearings – Personal hearings are held in Raleigh. The Hearing Unit will assign the date, time, and place. You will be notified in writing of the Hearing Officer's final decision after the personal hearing.

Paper reviews – You may instead send additional relevant documentation to the Hearing Unit for reconsideration. Your written material will then be evaluated and a final decision rendered.

Miscellaneous

If you or your staff need assistance or education, call EDS at 919-851-8888 or 1-800-688-6696 and request a provider education contact.

If you call EDS or DMA to get clarification of policy, it is helpful if you record the date, name of staff person talked with, the policy issue discussed, and a summary of the guidance given.

Providers have the responsibility to maintain the provider manuals and Medicaid bulletins and assure that all staff who plan care, supervise services, and file claims for Medicaid reimbursement have access to the Medicaid guidelines.

Self Referral Federal Regulation

The Omnibus Reconciliation Act (OBRA) of 1993 prohibits self referral by a physician to designated health services in which the physician has certain ownership of compensation arrangements. If post payment review determines that inappropriate payments were made due to the providers' failure to follow Medicaid policies, recoupments will be made. Exceptions are listed in OBRA 1993 and in section 1877 of the Social Security Act.

Designated health services include the following:

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|--|--|
| ?? clinical laboratory services | ?? home infusion therapy services |
| ?? physical and occupational therapy services | ?? radiology services (including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services) |
| ?? contact lenses | |
| ?? hearing aids | |
| ?? radiation therapy services | ?? durable medical equipment |
| ?? parenteral and enteral nutrition equipment and supplies | ?? comprehensive outpatient rehabilitation facility services |
| ?? prosthetic and orthotic devices | ?? outpatient drugs |
| ?? home dialysis | ?? home health services |
| ?? ambulance services | ?? inpatient and outpatient hospital services |
| ?? eyeglasses | |

Reporting Changes in Provider Information

Provider Changes Requiring Notification

Opticians must report all changes in provider status to DMA using the Notification of Changes in Provider Status form (see Attachment B).

Optometrists and ophthalmologists must report changes in their provider status to their regional BCBS Representative.

If you are also participating in the Medicaid program as a Managed Care provider, changes must be reported to your local Managed Care Representative (MCR).

Refer to Appendix B for telephone numbers.

Advance Directives

Background

Section 4751 of the OBRA 1990, otherwise known as the Patient Self-Determination Act, requires certain Medicaid providers to provide written information to all patients 18 years and older about their rights under state law to make decisions concerning their medical care, to accept or refuse medical or surgical treatment, and to execute an advance directive (e.g., living will or health care power of attorney).

Effective January 1, 1998, a new law entitled “An Act to Establish Advance Instruction for Mental Health Treatment” (NCGS §122C-71–§122C-77) became effective. The law provides a method for an individual to exercise the right to consent to or refuse mental health treatment if the individual later becomes “incapable” (i.e., lacks the capacity or ability to make and communicate mental health treatment decisions). The advance instruction becomes effective when delivered to the individual’s physician or mental health treatment provider, who then makes it part of the individual medical record.

Advance Directives Brochure

DMA, in conjunction with an advisory panel, has developed the required summary of state law concerning patients’ rights that must be distributed by providers. This brochure is entitled “Medical Care Decisions and Advance Directives: What You Should Know.” A print ready copy is available in Attachment A at the end of this chapter.

The two-page brochure can be photocopied on the front and back of one sheet of paper and folded in half to form a four-page brochure. Indicate in the box on the last page a contact for the patient to obtain more information. The brochure should be copied as is. If providers choose to alter the document graphically, they may not change or delete text, or the order of paragraphs. A provider-published pamphlet must include the N.C. Department of Health and Human Services’ logo and production statement on page four of the folded brochure.

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Doctor and each health care agent you named of the change. You can cancel your advance instruction for mental health treatment while you are able to make and make known your decisions, by telling your doctor or other provider that you want to cancel it.

Whom should I talk to about an advance directive?

You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your doctor or health care provider can answer medical questions. A lawyer can answer questions about the law. Some people also discuss the decision with clergy or other trusted advisors.

Where should I keep my advance directive?

Keep a copy in a safe place where your family members can get it. Give copies to your family, your doctor or other health/mental health care provider, your health care agent, and any close friends who might be asked about your care should you become unable to make decisions.

What if I have an advance directive from another state?

An advance directive from another state may not meet all of North Carolina's rules. To be sure about this, you may want to make an advance directive in North Carolina too. Or you could have your lawyer review the advance directive from the other state.

Where can I get more information?

Your health care provider can tell you how to get more information about advance directives by contacting:

This document has been developed by the North Carolina Division of Medical Assistance in cooperation with the Department of Human Resources Advisory Panel on Advance Directives 1991. Revised 1999.



Medical Care Decisions and Advance Directives What You Should Know

What are My Rights?

Who decides about my medical care or treatment?

If you are 18 or older and have the capacity to make and communicate health care decisions, you have the right to make decisions about your medical/mental health treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your doctor or mental health provider. If you want to control decisions about your health/mental health care even if you become unable to make or to express them yourself, you will need an "advance directive."

What is an "advance directive"?

An advance directive is a set of directions you give about the health/mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

Do I have to have an advance directive and what happens if I don't?

Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions; and you have no living will, advance instruction for mental health treatment, or a person named to make medical/mental health decisions for you ("health care agent"), your doctor or health/mental health care provider will consult with someone close to you about your care.

Living Will

What is a living will?

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally and incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatments that would delay your dying, for example by using a breathing machine (“respirator” or “ventilator”), or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube (“artificial nutrition or hydration”).

Health Care Power of Attorney

What is a health care power of attorney?

In North Carolina, you can name a person to make medical/mental health care decisions for you if you later become unable to decide yourself. This person is called your “health care agent.” In the legal document you name who you want your agent to be. You can say what medical treatments/mental health treatments you would want and what you would not want. Your health care agent then knows what choices you would make.

How should I choose a health care agent?

You should choose an adult you trust and discuss your wishes with the person before you put them in writing.

Advance Instruction for Mental Health Treatment

What is an advance instruction for mental health treatment?

In North Carolina, an advance instruction for mental health treatment is a legal document that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide yourself. The designation of a person to make your mental health care decisions, should you be unable to make them yourself, must be established as part of a valid Health Care Power of Attorney.

Other Questions

How do I make an advance directive?

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the doctor or other provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be written and signed by you while you are still able to understand your condition and treatment choices and to make those choices known. Two qualified people must witness all three types of advance directives. The living will and the health care power of attorney also must be notarized.

Are there forms I can use to make an advance directive?

Yes. There is a living will form, a health care power of attorney form and an advance instruction for mental health treatment form that you can use. These forms meet all of the rules for a formal advance directive. Using the special form is the best way to make sure that your wishes are carried out.

When does an advance directive go into effect?

A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care choices. When you make a health care power of attorney, you can name the doctor or mental health provider you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor or mental health provider. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, your Health Care Power of Attorney may make treatment decisions for you. An advance instruction for mental health treatment expires after two years.

What happens if I change my mind?

You can cancel your living will anytime by informing your doctor that you want to cancel it and destroying all the copies of it. You can change your health care power of attorney while you are able to make and make known your decisions, by signing another one and telling your

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Return form to: **Provider Services, DMA, 2506 Mail Service Center, Raleigh, NC 27699-2506**

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Report all changes to the Division of Medical Assistance using this form.

If you are enrolled as a Carolina ACCESS provider, you must also report changes to the Managed Care Section using the *Carolina ACCESS Provider Information Change Form*.**

Ambulance Services
 Certified Registered Nurse Anesthetists
 Developmental Evaluation Centers
 DSS Case Management
 Federal Qualified Health Centers
 Head Start Programs
 Health Departments
 Hearing Aid Dealers
 HIV Case Management
 Independent Diagnostic Treatment Facilities
Independent Practitioners
 ?? Audiologists
 ?? Occupational Therapists
 ?? Physical Therapists
 ?? Respiratory Therapists
 ?? Speech Therapists
 Licensed Clinical Social Workers
 Licensed Psychologists
 Mental Health Centers
 Nurse Midwives
 Nurse Practitioners
 Optical Services
 Out-of-State Hospitals
 Planned Parenthood Programs
 Psychiatric Clinical Nurse Specialist
 Psychiatric Nurse Practitioners
 Public School Health Programs
 Residential Evaluation Centers
 School Based Health Centers

Report all changes to the Division of Medical Assistance using this form. Include a copy of your new CLIA certificate.

Independent Free-Standing Laboratories

**Report all changes to the Division of Medical
 December 2001**

Report all changes to the Division of Medical Assistance using this form. Include a copy of your new license.

Durable Medical Equipment Services
 Home Infusion Therapy Services
 Personal Care Services
 Pharmacies
 Private Duty Nurses

Report all changes to the Managed Care Section using the *Carolina ACCESS Provider Information Change Form*.**

Providers (except chiropractors, dentists, optometrists, osteopaths, medical doctors, podiatrists) must also report changes to the Division of Medical Assistance using this form.

Carolina ACCESS Providers

Report all changes to the Managed Care Section using the *Carolina ACCESS Provider Information Change Form* and to the N.C. Office of Research, Demonstrations, and Rural Health Development (919-733-2040).**

ACCESS II and ACCESS III Providers

Report all changes to the N.C. Office of Research, Demonstrations, and Rural Health Development (919-733-2040).

Providers (except chiropractors, dentists, optometrists, osteopaths, medical doctors, podiatrists) must also report changes to the Division of Medical Assistance using this form.

ACCESS II and ACCESS III Administrative Entities

Report all changes to your HMO.

HMO Providers

Report all changes to the DMA Managed Care section (1-888-245-0179 or 919-857-4022) and to the Division of Medical Assistance using this form.

HMO Risk Contracting Managed Care Plans

Report all changes to the Division of Medical Assistance using this form. The DMA Provider Services unit will contact you to obtain additional information as needed to complete your change request.

Community Alternative Program Services

Report all changes to the Division of Medical Assistance using this form.

Providers must also report changes to the Division of Facility Services by calling 919-733-1610.

If you are enrolled as a Carolina ACCESS provider, you must also report changes to the Managed Care Section using the *Carolina ACCESS Provider Information Change Form*.**

Adult Care Homes
 Ambulatory Surgical Centers
 Critical Access Hospitals
 Dialysis Centers
 Home Health Agencies
 Hospice
 Intermediate Care/Mental Retardation Facilities
 In-State Hospitals
 Nursing Facilities
 Portable X-Ray Suppliers
 Psychiatric Residential Treatment Facilities
 Residential Child Care Facility (Level II – IV)
 Rural Health Clinics

Physicians must report all changes to their regional Blue Cross and Blue Shield of North Carolina Representative.

If you are enrolled as a Carolina ACCESS provider, you must also report changes to the Managed Care Section using the *Carolina ACCESS Provider Information Change Form*.**

Physicians

?? Chiropractors
 ?? Dentists
 ?? Optometrists
 ?? Osteopaths
 ?? Medical Doctors
 ?? Podiatrists

Assistance using this form. Include a copy of your new accreditation from the Commission of Free-Standing Birthing Center.
Free-Standing Birthing Centers

Report all changes to EDS by calling 1-800-688-6696 or 919-851-8888 or submit changes in writing on company letterhead.
MQB Providers

****A copy of the *Carolina ACCESS Provider Information Change Form* is available on the Internet at www.dhhs.state.nc.us/dma or by calling the DMA Managed Care Section at 919-857-4022.**